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Abstract

Purpose: This article documents the presence of policy transfer on integrated care development, its global occurrence and shifts towards integrated care. It highlights the influence of supranational forces, the roles of policy transfer, and the relevance of policy translation in the development of integrated care.

Design/methodology: This article presents the findings of an international review of the policy transfer of integrated care, and the relevance of policy translation in integrated care development.

Findings: The global occurrence in integrated care, as evinced in this article, can be seen in the global shift towards integrated care in various countries. However, studies exploring the actual mechanism of policy transfer and policy translation in relation to integrated care across countries are limited. The study of integrated care through the lens of policy transfer is important, as it for example, explores the structural elements, including environmental and cognitive obstacles in the policy transfer process. Policy translation offers a social constructivist approach to explore the travel of ideas, and considers the multiple spatial and scalar contexts in which integrated care policy is implemented.

Originality/value: This article aims to advance policy transfer and policy translation as complementary frameworks to explain integrated care development. Second, it seeks to make novel and useful contributions to the debate about the development of integrated care, and to the wider arguments on policy transfer and policy translation and integrated care in other parts of the world.

1. Introduction

Current literature on integrated care has focused largely on the enablers and barriers in the development of integrated care, often at organisational levels, and does not explicitly explore and examine the policy transfer and policy translation of integrated care across countries and jurisdictions, and their associated challenges and implications (see examples: Cameron, 2016, SPICe, 2012, Humphries, 2015). This is in spite of the presence of, as evident in the literature, the borrowing of integrated care ideas and policies across jurisdictions, and the cross-jurisdictional learning that takes place among policymakers, policy entrepreneurs, governmental organisations, think tanks, and integrated care managers.

Dolowitz and Marsh (1996, p. 344) define policy transfer as: [A] process in which knowledge about policies, administrative arrangements, institutions etc. in one time and/or place is used in the development of policies, administrative arrangements and institutions in another time and/or place (Dolowitz and Marsh, 1996, p. 344). In addition to policy transfer, other writers have suggested the concept of policy translation as a more relevant concept, particularly in depicting the significance of policy agents in the process of the travel of ideas (Clarke et al., 2015, Lendvai, 2015, Mukhtarov, 2014). Policy translation refers to the “process of modification of policy ideas and creation of new meanings and designs in the process of the cross-jurisdictional travel of policy ideas” (Mukhtarov, 2014, p. 76). It locates the policy agents and emphasises the complexity and ambiguity of policy processes with an interpretive approach (Shore and Wright, 2011).

The empirical verification of policy transfer, and necessarily policy translation, in integrated care between countries at the global level can be traced through the observation of the transmission mechanisms of policy learning, as articulated by Dolowitz et al. (2000). These include research publications, articles available in the public domain, a state’s activities and involvement in international organisations related to integrated care, and its officials and politicians going on overseas study or tours. The presence of policy transfer in integrated care is also evidenced in comparative studies on integrated care policies and practices (Calciolari and Ilinca, 2011, Mur- Veeman et al., 2008, Oliver-Baxter et al., 2013, SPICe, 2012); financial incentives and integrated

resource management systems (European Observatory on Health Systems and Policies, 2013, Mason et al., 2014, The Scottish Government, 2010); and the development of models of integrated care (Nicholson et al., 2013, Suter et al., 2009). These studies are accessible online and are also testament to the efforts that countries have made to understand the phenomenon of the policy occurring elsewhere and how they compare. They are relevant as they may be seen as representing opportunities for policy transfer to occur.

The aim of this article is to define and describe the roles of policy transfer and the relevance of policy translation in integrated care development. It documents the presence of policy transfer on integrated care development, its global occurrence, the influence of supranational forces, and the global shifts towards integrated care. The paper then advances policy translation as a complementary and necessary framework that needs also to be considered, beyond policy transfer, to explain integrated care development. The paper also seeks to contribute to the debate about the development of integrated care, and to the wider arguments on policy transfer and policy translation and integrated care in other parts of the world.

Defining policy transfer and policy translation

The areas of study of policy transfer include the *description* (how policy transfer is done), *explanation* (why policy transfer occurs), and *prescription* (how policy transfer should be done) are commonplace in normal policy analysis (Evans, 2010a). Within the policy transfer analysis framework, the foci of study can be organised and expressed as seven fundamental questions (Dolowitz, 2003, Dolowitz and Marsh, 2000): why engage in transfer, who is involved in transfer, what is transferred, where from, what is the degree of transfer, what constrains and facilitates the policy transfer process, how is the transfer process related to policy success or failure?

The objects of policy transfer include policy goals, policy structure and content, policy instruments or administrative techniques, policy programmes, institutions, ideology, ideas, attitudes and concepts, and negative lessons (Dolowitz and Marsh, 1996). Evans and Davies (1999) proposed a dialectical approach involving a multi-level interdisciplinary perspective to

understand the policy transfer process, highlighting three broad sets of variables that may constrain policy transfer and policy-oriented learning. They comprise ‘cognitive’ obstacles in the pre-decision phase, ‘environmental’ obstacles in the implementation phase, and increasingly, domestic ‘public opinion’.

Evans (2010b) explains that ‘cognitive’ obstacles refer to the process by which public issues are recognised and defined in the pre-decision phase, the breadth and detail of the search conducted for ideas, the receptivity of existing policy agents and systems to policy alternatives and the complexity of choosing an alternative. ‘Environmental’ obstacles refer to the absence of effective cognitive and elite mobilisation strategies deployed by policy transfer agents, and include considerations such as broader structural constraints (institutional, political, economic and social) that impinge on the process of lesson-drawing, and the technical implementation constraints that inhibit or facilitate the process of lesson-drawing (Evans, 2010b).

Building on policy transfer, policy translation augments policy transfer as it considers the translation that takes place in policy transfer. This is largely attributable to the critiques of policy transfer framework. For example, policy transfer is said to imply mechanistic assumptions and a linear model of messaging from A to B in the policy transfer process, although what is translated is often somehow inferior, unreal and unoriginal (Lendvai and Stubbs, 2007). The definition of successful policy implementation may also be unclear, and a policy that succeeds in one dimension or for one set of people may fail in another dimension or for another set of people (Dolowitz and Marsh, 2012). Additionally, the distinction between where policy transfer begins and ends may also not be obvious (Stone, 1999), as policy innovation may also rely in part on prior knowledge (Hudson and Lowe, 2009).

Primarily, policy transfer is seen as lacking acknowledgement of the uncertainty, centrality of practice and complexity in the policy translation process (Freeman, 2009, Stone, 2012), and is thus associated with diminishing analytical returns (Peck and Theodore, 2015). Mutation, as a result of endogenous forces, often occurs from prior learning processes in the translation of ideas, standards or programmes, where the processes occur in a complex web (Peck and Theodore, 2015, Stone, 2012). Moreover, ideas about organisational forms or policies are also translated

through modification, simplification and editing, and are transformed so that they can travel across contexts more easily (Dussauge-Laguna, 2013). The policy transfer literature also fails to address the issue of the politics of scale, whereby the levels of any study are scaled up to a level at which power can be exercised more effectively (Lendvai and Stubbs, 2007, Lendvai and Stubbs, 2009, Mukhtarov, 2014).

Beyond policy transfer, policy translation emphasises the complexity and ambiguity of policy processes from an interpretive approach (Shore and Wright, 2011). It explains how policy ideas morph and are transformed as policy actors act on a particular geographical scale within the contingencies of the relevant politics and context (Clarke et al., 2015, Mukhtarov, 2014).

Policy translation is often associated with and used in conjunction with concepts such as policy assemblages, mobilities and mutations (McCann and Ward, 2013). It is akin to a social constructivist approach in the travel of policy ideas (Mukhtarov, 2014), and is associated with the ‘interpretive’, ‘constructionist/ constructivist’, ‘cultural’, ‘linguistic’, and discursive’ turns in policy studies (Clarke et al., 2015). It acknowledges the complex interactions between the multiple factors that influence the process (Mukhtarov, 2014, Stone, 2012), and argues against monocausal and linear accounts of agency and action (Clarke et al., 2015).

Policy translation seeks to unpack the socio-spatial complexities and multiplexities of movements, from transportation to migration, rather than a linear straightforward point A to point B transfer of policy (Jones et al., 2014, McCann and Ward, 2013). For example, Singapore had to adapt in modelling Wisconsin-Works (W-2) in the United States (Ng et al., 2012) to establish the work support programme in 2006. It also had to modify Japan’s management techniques Work Improvement Teams (WITs) and Quality Control, and New Zealand’s executive agency model (Common, 2004) in the translation process. Contextualising policy-making behaviours matters in policy translation, and it is productive of associations and articulations, and shapes how policy is imagined and interpreted when it travels from one context to another, across spatial and scalar fields (Clarke et al., 2015). Policy translation thus adds insights into understanding how varying policy agents at various scales, space and time, and

offers a useful augmenting lens for integrated care scholars to explore the development of integrated care in their context.

Integrated care and the global occurrence of its policy transfer

The thrusts towards integrated care among countries could be attributed to the global shared experience of a rapidly ageing population (UN, 2015, WHO, 2014a), an increasing burden of chronic diseases (WHO, 2014b, WHO, 2016), increasing healthcare costs (Chapman et al., 2014), a decreasing old-age support ratio across the nation (DOS, 2016), and a rising demand for healthcare (Cheah et al., 2012, Grone et al., 2001, MOH, 2014). Indeed, countries experiencing similar pressures and common shocks provoking similar national reactions look to other political systems for knowledge and ideas about institutions, programmes and policies, in order to explore their adoption and adaptation (Dolowitz et al., 2000, Freeman, 2006, Obinger et al., 2013).

The turning to other countries in response to the demographic and epidemiological changes, and drawing lessons from them to explore integrated care approaches, represents a form of policy transfer. This notion of improving policy-making by looking abroad and adopting policies from elsewhere is regarded as a common response to addressing policy issues (Carroll and Common, 2013), and can be seen as a strategy for transforming the state (Evans, 2010b). The underlying assumption is that policies that are successful in one country might also be successful in another (Dolowitz and Marsh, 2000). This idea is premised on the potential of policy transfer to improve the effectiveness of government operations, and is concerned with how it relates to policy outcomes (Marsh and Sharman, 2010).

The concept of integrated care has gained traction globally over the years. Policy shifts and health transformations towards integrated care through policy transfer are evident in policy articulations and initiatives in many countries. These are in part due to supranational forces in bringing about its development. As early as 1999, the WHO European Region proposed the strategy of integrating health services (WHO, 1998, WHO, 1999). This was followed by the establishment of the WHO European Office for Integrated Health Care Services, whose stated

aim was to encourage and facilitate changes in healthcare services to achieve quality, accessibility, cost-effectiveness and participation (Grone et al., 2001). In 2003, the WHO exhorted nations to adopt integrated care as one of the key pathways to improving primary care (WHO, 2003). In 2004, the European Commission declared integrated care to be crucial for the sustainability of social protection systems in Europe (Lloyd and Wait, 2005). Following this, in 2005, the WHO European Region stated the need to adopt a more general approach or ‘Health for All’ vision, involving a broad partnership approach to health to strengthen national health systems (WHO, 2005, p. 17).

The influence of supranational organisations has considerable implications for nations (Bennett et al., 2015, Obinger et al., 2013, Pal, 2014, Savi and Randma-Liiv, 2013) and reflects the ‘transnationalisation of policy’ (Stone, 2010, p. 270). Such transnational governance is framed through norms, practices and discourses, and is a complex, fragmented, unstable and highly contested arena (Kennett and Lendvai, 2014). These forces introduce an arguably negotiated policy transfer in action, and effective health governance at work. Such pressure demonstrates the influence that supranational forces have on countries in terms of achieving global objectives. It shows how policy-making can take place within the economic context of globalisation and the political context of global governance (Massey, 2010). Supranational forces such as the WHO thus constitute a form of global health diplomacy, and function as an interface between health, foreign policy and trade (Pang et al., 2010, Payne, 2008), where health is considered as both a global public good (Lamy and Phua, 2012) and a necessary focus for international policy development (Brown and Moon, 2012).

Policy transfer in global healthcare and health policy, and in integrated care

As a concept, policy transfer has been particularly important for global healthcare and health policy. Its global occurrence has been evident in several healthcare areas, such as in tuberculosis control (Bissell et al., 2011, Colvin et al., 2015, Ogden et al., 2003), gender mainstreaming and healthcare (Kuhlmann and Annandale, 2012, Payne, 2014), malaria and HIV/AIDS treatment (Ngoasong, 2011, Parkhurst et al., 2015), and childhood illness management (Bennett et al.,

2015). Increasingly, and given the globally shared experiences, such as the rapid ageing of the world's population (WHO, 2014a), the growing global burden of chronic diseases (WHO, 2014b), increasing global healthcare costs (Chan, 2010), and fragmented systems of care, countries have begun engaging in policy transfer in regard to integrated care as an approach to managing some of these issues as cost-effectively as possible (Fabbricotti, 2003, Viktoria Stein et al., 2013).

In integrated care development, the policy shift at the global level towards care integration is evident in the policy articulations and initiatives in many developed countries. A literature search made across countries that enacted policies to support the pursuit of integrated care development, showed that the UK, for example, has seen integrated care policy and practice being rolled-out over recent decades in all four of its constituents. In England, the enactment of The Health Act 1999, The Health and Social Care Act 2001, The Health and Social Care Act 2012, Care Act 2014, as well as the introduction of Sustainability and Transformation Plans, are testaments to its ongoing determination to mainstream integrated care into its health and social care policy and practice (Hammond et al., 2017, Legislation.gov.uk, 2014).

Similar policy shifts have also been seen in Canada. For example, in 2001, the Romanow Commission recommended that the Canadian healthcare system evolve from a system in which a multitude of participants work in silos and focus primarily on managing illness, to one where they work collaboratively (Romanow, 2002). The Respecting and Health Services and Social Services Act 2003 in Québec sought to establish an integrated health and social services organisation, to bring the entities closer to the general public, in order to facilitate the transition process through care pathways (Québec, 2006). However, there is also a need to take into account differences in jurisdictions and how they might differ in the development of integrated care. The Australian National Health and Hospitals Reform Committee also strongly recommended a focus on access and equity, vertical and horizontal service integration and the development of an agile and sustainable health system with a focus on primary health care (Connor et al., 2016).

In New Zealand, integrated care pilots have been implemented since the late 1990s in different service areas (Canterbury District Health Board, 2013). The more recent Integrated Family

Health Centres 2010; Better, Sooner, More Convenient Health care in the Community 2011; and the Statement of Intent 2012/13 to 2014/15, and the Integrated Performance and Incentive Framework (IPIF) of 2014, reflect its government's strategic goals and policy decisions towards healthcare reform that facilitates integrated care (Ashton, 2015, Letford and Ashton, 2010, Ministry of Health, 2011, Ministry of Health, 2012). Healthcare reform in the US, through the implementation of the Patient Protection and Affordable Care Act 2010, for example, seeks to provide "a comprehensive, integrated health insurance reform programme for those who are eligible to enrol"; indeed, one of its key features is the aim to integrate primary health, behavioural health and related services (Kuramoto, 2014, p. 44). Similar shifts have also been seen in Sweden since the 1990s, where there have been efforts to integrate healthcare focused on the integration of intra-organisational processes (Ahgren and Axelsson, 2011, Anthony et al., 1989), and now on the development of chains of care in the health and social care settings (Ahgren, 2003, Ahgren and Axelsson, 2011). Policy shifts towards integrated care are also evident in other countries, such as Finland, Austria, Spain and The Netherlands (Mur-Veeman et al., 2008).

While the above evidences the presence of policy transfer across countries, it is less clear how the actual mechanisms and roles of policy transfer, and necessarily policy translation occur in the development of integrated care. For example, it is unclear how policy ideas on integrated care get transferred and thereby translated in the process. What is transferred, who does the transfer, where the idea is from, and what the facilitators and constraints in the transfer process are, are unknown. It is also less clear how varying understanding of integrated care, across space, time and contexts, and by the various stakeholders influence the translation of the policy. These considerations are important as they could determine what gets transferred, by whom, and who benefits and losses in the process. With more than 70 terms and phrases, and about 175 definitions and concepts in relation to integration (Armitage et al., 2009), there is also a need to be clearer in terms of the definition of integrated care by which the policy is being transferred and translated in the process.

It would be crucial therefore to explore how varying understanding of integrated care and differences in context can influence its development in a way that is coherent, meaningful and

important to a context, which can be defined by its culture, political structure, economics and other technical factors. Understanding the role of contextual influences and differences when comparing federal and provincial policies would be crucial in the policy translation of integrated care.

The dearth of studies in this regard underscores the need for more case and comparative case studies at national and jurisdictional levels. It would mean exploring what factors influence the development of integrated care through the lenses of policy transfer and translation, and can be used to explain the differing development of integrated care across jurisdictions. This also points to the relevance of policy transfer and policy translation to studying integrated care development.

Conclusion

As countries explore and learn from one another on integrated care approaches, it is essential to be cognisant of the influences of policy transfer and the factors to be considered in the policy transfer and policy translation process. Policy transfer and policy translation offer a lens through which to explore integrated care development by identifying the multi-site and multi-scalar networks at work, accounting for differences in contextual features, and by making explicit the complexity of various processes when policy ideas travel across space and time, which are crucial to integrated care development. One of the main challenges in the current literature is the lack of research studies exploring and articulating the actual mechanisms or illustration of how transfer and translation have occurred globally. While this paper highlights the presence of ongoing policy transfer in integrated care, as evinced by the mushrooming of integrated care policies across jurisdictions, it underscores the need for more research in this regard to explore the actual mechanism of policy transfer and translation of integrated care. This article offers policy transfer and policy translation as augmenting lenses, and an alternative framework, to explore integrated care development.

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